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ABSTRACT

Summaries of arguments given in the literature both for and against the use of verbal-traditional psychotherapy with mentally retarded individuals is presented. Much research examines process variables in therapy as an approach. Feedback variables are crucial. Results of a research study in which therapy groups composed of mentally retarded adults underwent manipulations designed to affect delivery of feedback within the group are reported. Therapist style, race, and time, but not sex, affected feedback. Feedback may increase self-reinforcement and less reliance on the opinions of other people. (Author/BEF)

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GROUP PSYCHOTHERAPY WITH MENTALLY RETARDED ADULTS

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Let me begin by giving you some personal background--to give you an idea of how I got interested in this field of research. I began doing volunteer work with mentally retarded individuals when I was 13 years old, and quickly became involved in an organization called the National Association for Retarded Citizens (NARC) and its youth division. My involvement in this organization led me to develop a personal approach to the field which emphasizes normalization, a developmental model of mental retardation, and human rights. In addition, as a youth volunteer, my primary role was that of a friend to mentally retarded individuals.

I completed undergraduate study at the College of Idaho, and came to Florida State University to do research with Dr. Jack May--who shared my involvement in NARC. I immediately became involved as a co-therapist in his therapy groups for mentally retarded adults from boarding homes. At the time I became involved, the format was one of traditional verbal group therapy. I was told, however, that the groups started out as structured skill-teaching groups,

using a group behavior modification approach. By the time I became involved, however, the groups had become typical verbal therapy groups. There appeared to be two reasons for this evolution:

a) It was more interesting for the therapists; and

b) The clients demanded this approach! They frequently came in with problems which required discussion and resolution before the structured sessions could begin.

At this same time, I was searching for research ideas--and had finally decided on using structured group behavior modification to teach social skills to individuals who are mentally retarded. BUT--then I talked to a very eminent researcher in the field of psychotherapy; and casually mentioned the therapy groups I was involved in. He was amazed, and repeatedly asked, "You mean you sit around and talk with retarded people?"

Until that point, I had begun to take it for granted that everyone knows that mentally retarded people have feelings, conflicts, and problems; and a need to be listened to, to be understood, and to be taken seriously. But I suddenly realized that many professionals in my field--clinical psychology--as well as in related fields--hold outmoded stereotypes regarding mentally retarded individuals. I recognized the great need for research to demonstrate and investigate the efficacy of verbal-traditional group psychotherapy with mentally retarded adults.

Having recognized this need, I went to the literature--and found numerous traditional arguments against the use of psychotherapy with mentally retarded adults. The two most prevalent arguments were:

a) Mentally retarded people lack adequate verbal skills to benefit from psychotherapy; and

b) People who are mentally retarded lack insight, which is a prerequisite to successful psycotherapy.

Prior to the early 50's, these views were generally accepted; and especially reinforced by nondirective therapists and psychoanalysts, including Rogers and Freud.

There were other reasons contributing to the lack of research and practice ir this field:

-----One factor was the persistence of inappropriate aims of psychotherapy with this population. The stated aim was often to raise the IQ to normal; and if this outcome did not occur, the therapy was deemed a failure.

-----In addition, many personality theories emphasized the irrevocable organic factors which cause mental retardation and, supposedly, all associated behaviors--leading to the conclusion that behavior disorders in mentally retarded persons are untreatable.

-----It was also argued that mentally retarded people were less likely to have "mental conflict" or "psychic distress".

-----Practical arguments were presented: such therapy was

said to be too time-consuming and expensive.

-----Research suggesting that normal to bright IQ adolescent males improved with therapy more than "dull" adolescent males was seized upon, and frequently cited as evidence that therapy was inappropriate for mentally retarded individuals.

The literature, however, is also full of rebuttals to these arguements:

-----It was argued that low IQ is not a contraindication to therapy: that a retarded person can still establish a relationship with a therapist and undergo a corrective emotional experience and/or achieve sufficient insight to benefit from therapy.

-----It was recognized that the aim of therapy with this population, as with all populations, is to deal with behavior disorders and the crippling effects of emotional conflicts--NOT to raise the IQ to a normal level.

-----It was increasingly recognized that personality patterns vary in mentally retarded people, as in normal IQ people; and that there are numerous causes of the syndrome of mental retardation and its associated behaviors.

-----The need for therapy was recognized and established. The incidence of mental illness and behavior disorders in mentally retarded persons is at least as great as in the general population.

-----As for practical considerations--humane practitioners

began to note that therapy is worthwhile in and of itself if it helps the client become more comfortable and/or better adjusted. It was also noted, however, that psychotherapy with this population can result in time, staff and money savings.

-----Methodological flaws in the previous research were noted. For instance, the oft-cited study comparing response of "dull" and normal boys to psychotherapy had no controls for social class differences between the two groups.

The literature also yields numerous anecdotes, case studies, and descriptive data testifying to the success of psychotherapy with mentally retarded persons. Much of the research which does exist is in the form of outcome studies--and the need for process research in this field is just now being recognized. This approach--of examining process variables in therapy--was the one which I chose in my own research.

We selected feedback as a crucial variable, and measured this as follows: Each member of the therapy group had a cupful of "good" chips, which he or she was instructed to give to other members and/or the therapists if he/she liked what that other person said or did. Each person also had a cupful of "bad" chips--to be given if she/he didn't like what another person said or did.

The independent variables we looked at included:

a) Therapist style: In some sessions the therapists

made only reflective comments; in other sessions they asked questions designed to elicit information (such as "How did you feel?", "What happened next?");

b) Amount of structure: In half the sessions the therapists came prepared with discussion questions--in the other sessions, the clients were largely responsible for bringing up topics.

Two groups were run--each for 16 sessions, over a period of 6 months. The clients were from rural southern Georgia; and were predominantly black. IQs ranged from less than 30 to 69 (average IQ=53). The clients ranged in age from 16 to 34 (average age=24). Presenting problems included a wide range of interpersonal and behavioral problems... ranging from shy clients to aggressive clients; from non-verbal clients to those who spouted constant meaningless chatter; from acting-out clients to those who were overly inhibited.

Preliminary results of the data analysis suggest some very interesting findings:

1. Many more good chips were given than bad chips. We had expected this finding, as mentally retarded people often have difficulty expressing negative emotions--and especially so in a southern subculture which emphasizes politeness.
2. Slightly more good chips were given to each member, on the average, than to each therapist, on the average. This outcome could be viewed as a desirable goal of

group therapy; reflecting more member-member interaction than member-therapist interaction.

3. There is a very strong race effect; as well as a race by treatment effect. Black clients gave fewer chips than expected--except in very structured settings. This was true even though there were five black and two white members in each group. This effect might be explained, in part, by the presence of three white co-therapists, combined with a prevailing community attitude of condescension toward blacks by whites. This attitude is so strong that many blacks have adopted it as their own. One of my black clients, upon learning that I was to be replaced by a black psychologist trainee, became quite upset. Upon questioning, she stated "I don't want no black therapy teacher. I never had one and they just ain't as good as white ones." When bad chips were examined separately, however, it was found that blacks delivered more bad chips than expected!
4. There were no sex differences.
5. Several time effects were found. Bad chip delivery decreased with time; possibly the opportunity for such delivery lost its novel value.

   There also appeared to be an order effect with good chips. The number of good chips increased with repeated presentations of the same experimental treatment. For instance, the first time the therapists

used reflection in a structured setting fewer chips were delivered than the fourth time they used this treatment.

6. No treatment effects were found for bad chips. For good chips, the more structured the setting, the more chips were delivered. Apparently, these clients felt more comfortable in the structured settings.

7. An unexpected finding was that of spontaneous self-reinforcement: both good and bad chips were self-delivered. One girl slapped her hand and gave herself a bad chip upon making a "nasty" comment. I am tempted to speculated that, in this setting, the self-delivery of good chips reflected a low self-image; and may have compensated for low chip delivery from other clients.

These findings suggest two future directions for research in this field:

1) Increasing bad chip delivery; and

2) Increasing self-reinforcement. These two outcomes would essentially involve the delivery of more bad feedback to others and more feedback--good and bad--to oneself. Hopefully, this would reflect the development of increasing reliance on one's own self-perceptions and less reliance on the opinions of other people.